Department of Managed Health Care
980 Ninth Street
Suite 800
Sacramento, CA 95814-2738
Attn: Angela Yee

Plan Reporting Verification by Principal Officer

Plan License #: _____

Entity Name:_____

Address: _____

City: _____ State:_____ Zip Code:_____

Telephone Number: _____

Survey(s) Submitted:

Quarterly ____ Period Covered _____

Annual ____ Period Covered _____

Date Survey was submitted to the DMHC: _____

I certify (or declare) that I have read and reviewed the above-referenced survey(s) and any attachments thereto and know the contents thereof, and that the statements therein are true and correct to the best of my knowledge and belief.

I further certify (or declare) that for any quarterly reporting period referenced above the plan has complied with all the risk arrangement disclosure requirements of Regulation1300.75.4.1 of Title 28 of the California Code of Regulations.

Executed at _____ on _____.

Signature:_____
Title:_____